

**MONTANA BOARD OF MEDICAL EXAMINERS**  
**P. O. Box 200513**  
**(301 S PARK, 4<sup>TH</sup> FLOOR - Delivery)**  
**Helena, Montana 59620-0513**  
**(406) 841-2361 or (406) 841-2364      FAX (406) 841-2305**  
**E-MAIL: [dlibsdmed@mt.gov](mailto:dlibsdmed@mt.gov)      WEBSITE: [www.medicalboard.mt.gov](http://www.medicalboard.mt.gov)**

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.  
(Please allow 30 days for processing from the date that the Board has a complete routine application)

**PHYSICIANS ARE NOT PERMITTED TO PRACTICE MEDICINE IN MONTANA IN ANY MANNER**  
**WITHOUT AN ACTIVE MONTANA LICENSE**

**LICENSING REQUIREMENTS:**

- ◆ Must be a graduate of a medical school approved by the American Osteopathic Association or the Council for Medical Education of the American Medical Association.
- ◆ U.S. graduates must complete at least 2 year post-graduate training in an approved program in the United States or Canada. (For Montana Family Residency Program see Board Statute 37-3-305(4), MCA)
- ◆ Foreign graduates must complete at least 3 years post-graduate training in an approved program in the United States or Canada or been granted board certification by a specialty board which is approved by AMA or AOA.
- ◆ Foreign graduates must have a certificate from the Educational Council for Foreign Medical Graduates (ECFMG).
- ◆ Must have passed a licensing exam, approved by the Board, with a score of at least 75% on all portions of the examinations. (Please refer to the Board statutes and rules (ARM 24.156.606) for specific information regarding examination information and limits on attempts.)
- ◆ Must be of good moral character

**FEES:**            **\$325.00 – Application Fee** \*Make payable to Montana Board of Medical Examiners\*\*

**PHOTOS:**      Attach one photo to page 3, and one to page 8 of the application. Passport size is preferable.

**DOCUMENTS:**      The following documents must be submitted to the Board office in order to complete your license application.

**U. S. GRADUATES**

Certification of Medical Education  
Internship Diploma  
Residency Diploma  
Specialty Board Certificate(s)  
Recent DEA Query Form  
DD214, Military Discharge Paper (if applicable)  
Recent National Practitioner Databank (NPDB) self-  
query (Letter Unopened)  
Current Verification from all State Licensing Boards  
Examination Scores

**FOREIGN GRADUATES**

Certification of Medical Education  
Residency Diploma  
5th Pathway Certificate  
E.C.F.M.G. Certificate and Verification  
Verification of Examination Scores  
Specialty Board Certificate(s)  
Recent DEA Query Form  
Recent National Practitioner Databank (NPDB) self-  
query (Letter Unopened)  
Current Verification from all State Licensing Boards  
DD214, Military Discharge Paper (if applicable)

**NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY CERTIFIED TRANSLATIONS.**

**ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:**

- ◆ **National Practitioner Data Bank (NPDB) self-query.** This form can be obtained by calling NPDB at 800-767-6732 or visit [www.npdb-hipdb.com](http://www.npdb-hipdb.com) on the Internet. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please forward them to the Board office.
- ◆ **DEA QUERY FORM.** This form must be sent directly to the address indicated. The results will come directly to the Board office. There is no fee required.
- ◆ **EXAM SCORES.** Forms can be obtained from the National Board of Medical Examiners at <http://www.nbme.org/> or the Federation of State Medical Boards at [www.fsmb.org](http://www.fsmb.org) for USMLE or FLEX scores or National Board of Osteopathic Medical Examiners (773) 714-0622. Please use the appropriate form to request exam scores and send directly to the Board office. For all other exams, contact the testing entity for your scores.
- ◆ **REQUEST FOR STATUS REPORT FROM ECFMG.** This form is only required of Foreign Medical Graduates. Submit the form to ECFMG with the required fee. The results will be mailed directly to the Board office.
- ◆ **CERTIFICATE OF MEDICAL SCHOOL.** You must complete the bottom portion of page 8, including a current photo, in front of a notary and send the form to your medical school. The top portion of page 8 must be completed by school officials and sent directly back to the Board office.

**APPLICATION PROCEDURES:**

- ◆ When the application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- ◆ If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.
- ◆ All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.
- ◆ Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

**PROCESSING PROCEDURES:**

- ◆ Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.
- ◆ The applicant will be notified in writing of any deficient or missing items from the application file.
- ◆ Please be sure the three individual references you listed on your application complete the reference questionnaire form and return the form directly to the Board office as soon as possible in order to complete your application.
- ◆ Once a routine application is processed and approved a permanent license will be issued.

**For information with regard to the processing of this application or other concerns please contact the Board of Medical Examiners staff at (406) 841-2361 or (406) 841-2364 or email us at [dlibsdmed@mt.gov](mailto:dlibsdmed@mt.gov)**

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE ON OUR WEBSITE: [www.medicalboard.mt.gov](http://www.medicalboard.mt.gov)

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AFFIX PHOTO  
HERE  
PASSPORT SIZE

Application for Licensure as:

☐

Medical Doctor

☐

Doctor of Osteopathy

**Allow 30 days from the date the Board has a complete routine application file for licensure.**

1. FULL NAME: \_\_\_\_\_  
Last First Middle

2. OTHER NAME(S) KNOWN BY \_\_\_\_\_

3. BUSINESS NAME \_\_\_\_\_

4. BUSINESS ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

5. HOME ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS \_\_\_\_\_

6. TELEPHONE (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Business Home Fax

7. SOCIAL SECURITY NUMBER \_\_\_\_\_ FOREIGN ID NUMBER \_\_\_\_\_

8. DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_  
City/State ☐ MALE ☐ FEMALE

9. LICENSE NAME \_\_\_\_\_  
(State your name as it should appear on the license if granted.)

10. Which exam did you take for initial licensure?  
☐ National Boards ☐ FLEX ☐ USMLE ☐ LMCC ☐ State Exam (indicate which state) \_\_\_\_\_

11. If you are a foreign medical graduate, have you satisfied the requirements of the Education Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

12. Do you intend to practice in the State of Montana? If yes, attach a brief explanation. ☐ Yes ☐ No

13. Have you ever previously applied for a license to practice in Montana? If yes, give date, and results. ☐ Yes ☐ No

14. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach a detailed explanation. ☐ Yes ☐ No

15. Have you ever withdrawn an application for medical licensure? If yes, please give the state and reasons for withdrawal. ☐ Yes ☐ No

16. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

17. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements. ☐ Yes ☐ No
18. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No
19. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No
20. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No
21. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No
22. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation. ☐ Yes ☐ No
23. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No
24. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines and (2) charges or convictions prior to your 16th birthday. If yes, please attach a detailed explanation. ☐ Yes ☐ No

25. Have you any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No

26. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No

**27. PROFESSIONAL EDUCATION:**

Name of University or College	City and State/Province/Territory	Dates Attended	Degree Earned

Name of Medical School	City and State/Province/Territory	Dates Attended	Degree Earned

Internship Program	City and State/Province/Territory	Dates Attended	Diploma Received
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Residency Program	City and State/Province/Territory	Dates Attended	Diploma Received
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Fellowship	City and State/Province/Territory	Dates Attended

28. Have you ever been certified by a Specialty Board? ☐ Yes ☐ No

Certifying Agency	Specialty	Date Awarded, Re-certified

Have you ever been denied specialty certification or failed to pass a specialty certification examination or portion thereof? ☐ Yes ☐ No

By whom? \_\_\_\_\_

Reason for denial? \_\_\_\_\_ Number of times failed \_\_\_\_\_

**29. PRACTICE HISTORY:** List **all** activities after medical school (other than those already set forth above) in chronological order, up to and including the present. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. (If medical practice, indicate nature of practice.) **Account for all periods of time longer than 1 month. Indicate specific month and year for each activity.** Use additional paper if necessary.

Name & Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

**30. PROFESSIONAL & CHARACTER REFERENCES.**

Please type or print names and addresses of three references (must be MD or DO), who have known you or associated with you for a minimum of one year.

Name:
Address:
Telephone Number:

Name:
Address:
Telephone Number:

Name:
Address:
Telephone Number:

**AFFIDAVIT**

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

\_\_\_\_\_  
Legal Signature of Applicant

\_\_\_\_\_  
Date

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Signature of Notary Public

SEAL

\_\_\_\_\_  
Notary Public Printed Name

\_\_\_\_\_  
For the State of

My commission expires \_\_\_\_\_, \_\_\_\_\_.

## CERTIFICATE OF MEDICAL EDUCATION

(Please forward this form to medical school for certification of applicant's medical degree)

**Do not make this endorsement unless applicant has affixed a PHOTOGRAPH and completed the AFFIDAVIT.**

**Please complete and return form directly to: BOARD OF MEDICAL EXAMINERS, PO BOX 200513,  
HELENA MT 59620-0513**

It is hereby certified that \_\_\_\_\_ of \_\_\_\_\_

Graduated from \_\_\_\_\_ Location \_\_\_\_\_

Date Graduated \_\_\_\_\_, and is to the best of our knowledge is of good moral character.

(SEAL OF SCHOOL)

President, Dean or Registrar Signature \_\_\_\_\_

Date Certified \_\_\_\_\_

AFFIX PHOTO  
HERE  
PASSPORT SIZE

### AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

Legal Signature of Applicant \_\_\_\_\_

Dated \_\_\_\_\_

Subscribed and sworn to by me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Signed Name of Notary Public

**SEAL**

\_\_\_\_\_  
Printed Name of Notary Public

\_\_\_\_\_  
For the State of

My commission expires \_\_\_\_\_, \_\_\_\_\_.

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**TO THE APPLICANT**

Please complete the identifying information and submit to:

**DEA SALT LAKE CITY DO  
DIVERSION GROUP  
ATTN: CHAR MESSICK, R T  
348 E S TEMPLE  
SALT LAKE CITY, UT 84111-1202**

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Date: \_\_\_\_\_

To Whom It May Concern:

I am applying for a license to practice medicine in the State of Montana. Please indicate on the lower portion of this form if there is any derogatory information on file against me. I hereby specifically authorize the release of any and all information concerning me, and agree to hold the DEA harmless from any liability for the disclosure of such information. Please send this form directly to the Montana Board of Medical Examiners. Thank you for your assistance.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

DEA Registration Number: \_\_\_\_\_

Address where DEA Number is registered: \_\_\_\_\_

---

Legal Signature of Applicant

---

Please Print Name

---

DEA RESPONSE:

**MONTANA BOARD OF MEDICAL EXAMINERS**

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**VERIFICATION OF MORAL/PROFESSIONAL CHARACTER**

**APPLICANT:** Complete the upper portion of this form and mail to each of the character references you have listed in your application (page 6).

\_\_\_\_\_  
Legal signature of Applicant

\_\_\_\_\_  
Date

(Please Type or Print):

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

This verification sent to: \_\_\_\_\_

**CHARACTER REFERENCE:** Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Medical Examiners. Your response will be kept confidential.

Name of reference: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Address: \_\_\_\_\_

Title/profession/position: \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_ In what capacity? \_\_\_\_\_

To your knowledge, does this applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes," please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you consider this applicant worthy of approval to practice as a physician in Montana? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Reference

\_\_\_\_\_  
Date

The Applicant and the Board thank you for your assistance.

**VERIFICATION OF LICENSURE**

THIS IS NOT AN ENDORSEMENT CERTIFICATION

**PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.**

STATE BOARD:

I am applying for a license to practice medicine in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

\_\_\_\_\_  
(Signature) Name: \_\_\_\_\_  
(Please print)

Address: \_\_\_\_\_

My License Number is: \_\_\_\_\_

**DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS**

State of: \_\_\_\_\_

Full Name of Licensee: \_\_\_\_\_

License No. \_\_\_\_\_ Issue Date: \_\_\_\_\_

License is current? \_\_\_\_\_ If NO, explain \_\_\_\_\_

Has license been suspended, revoked, placed on probation or otherwise disciplined? \_\_\_\_\_

If YES, explain and attach documentation \_\_\_\_\_

Has licensee ever been requested to appear before your Board? \_\_\_\_\_

If YES, explain \_\_\_\_\_

Derogatory information, if any \_\_\_\_\_

Comments, if any \_\_\_\_\_

**BOARD SEAL**

Signed: \_\_\_\_\_  
Title: \_\_\_\_\_  
State Board: \_\_\_\_\_ Date: \_\_\_\_\_

## EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUTES

### REQUEST FOR STATUS REPORT OF ECFMG CERTIFICATION

Reports will be sent directly to the STATE MEDICAL BOARD.

**\*\*PLEASE ATTACH A CHECK FOR \$25 TO THIS REQUEST\*\***

Checks should be made payable to ECFMG in U. S. dollars. Status Reports will be mailed directly to the State Medical Board indicated below. Requests without payment attached will not be processed.

To confirm ECFMG certification status for a graduate of a foreign medical school, please complete and return this from to:

**ECFMG Certification Verification Service**

**PO Box 820424**

**Philadelphia, PA 19182-0424**

**Please type or print.**

**Requests with incomplete or inaccurate information will not be processed.**

**USMLE™/ECFMG Identification Number:**

**0** -    -    -

Physician's Name: \_\_\_\_\_  
First Middle Last Name/Surname/Family Name

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

Name of State Medical Board that Status Report should be sent to:

MONTANA BOARD OF MEDICAL EXAMINERS

State Board Contact: BRENT GOETSCH LICENSING TECHNICIAN  
(if applicable) Name Title

Telephone number (with area Code): 406 - 841-2361

☐ Check/money order for \$25 (made payable to ECFMG in U. S. dollars) is enclosed.

Note: Requesting organizations must secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the ECFMG certification information or make it available to any party beyond this request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

Physicians who are ECFMG-certified have passed the requisite medical science examination, English language proficiency test and, effective July 1, 1998, the ECFMG Clinical Skills Assessment, if required for ECFMG certification, and have had their medical education credentials verified by ECFMG. ECFMG certification is prerequisite for entry into ACGME-accredited residency or fellowship programs in the United States; is required by most states for licensure to practice medicine in the United States; and is one of the eligibility requirements to take USMLE step 3.